Kansas State Employees

Health Care Commission
ANNUAL REPORT

2005 Plan Year

Kansas State Employees Health Care Commission
Annual Report
2005 Plan Year

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EXHIBITS

BACKGROUND

The Kansas State Employees Health Care Commission (HCC) was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et. seq.… to "develop and provide for the implementation and administration of a state healthcare benefits program. . . It may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, non-medical remedial care and treatment rendered in accordance with a religious method of health and other health services." Under K.S.A. 75-6504, the HCC is authorized to "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the state healthcare benefits program."

The HCC is composed of five members and met four (4) times during 2005. The Secretary of Administration and Commissioner of Insurance serve as members of the HCC as mandated by statute, while the Governor appoints the other three members. The statute requires one member to be a representative of the general public, one member to be a current state employee in the classified service, and one member to be a retired state employee from the classified service. Present members are:

Duane Goossen, Chair and Secretary of Administration
Sharon Bolyard, employee from the classified service
Connie Hafenstine, retiree from the classified service
Sandy Praeger, Commissioner of Insurance
John Staton, representative from the general public

The Segal Company provides actuarial and consulting services to the HCC. Segal is an independent consulting firm specializing in employee benefits, compensation, actuarial services and human resource management with offices located in the United States and Canada. The consultant contract was awarded beginning in 2004 and runs through December 2006.

An Employee Advisory Committee (EAC) assists the HCC. It is composed of 21 members, 18 of who are active employees and three who participate through Direct Bill. Members are selected on the basis of geographic location, agency, gender, age, and plan participation in order to assure that a balanced membership representing a broad range of employee and Direct Bill participant interests are represented. Each member serves a three-year term. (Exhibit A) The EAC met four (4) times during 2005. Its three sub-committees held additional meetings.

The Commission implemented the Statewide Student Insurance Program Advisory Committee (SAC) in 2003. It serves in an advisory capacity to the Commission with members from the Board of Regents, each of the universities under the Board of Regents and the Kansas University Medical Center (Exhibit B). The SAC met four (4) times during 2005.

PLAN YEAR 2005 EXECUTIVE SUMMARY

- The Plan is in good financial standing with much lower cost trends than seen in the immediate past. Analysis of the 2005 utilization data indicates that the positive trends established in PY 2004 continued in PY 2005.

- Plan Year 2005 was the fourth year and final for the current medical contracts, the second year of the dental and pharmacy benefit management (PBM) contracts, and the third year for the vision contract.

- The generic dispensing rate increased to 50.8% in PY 2005 compared to 37% in Plan Year 2002.

- Staff conducted a listening tour in April 2005 visiting several locations across the state to determine the effectiveness of employee benefits education, open enrollment and to obtain feedback from the human resource officers and employees regarding the current plan design, the employer contribution and interest in a Qualified High Deductible Health Plan.

- As of the fall 2005 semester, 2,522 students and 1,769 Graduate Research or Graduate Teaching Assistants were enrolled in the Statewide Student Insurance program.

- The HCC approved increasing the employer contribution for dependent coverage to an average of 45% effective with Plan Year 2006.

- The HealthyKIDS program was implemented which provides an employer contribution of 90% towards health insurance premium for low-income families.

- As of December 2005, ninety (98) groups were enrolled in the Non State plan with 6,081 contracts, representing 12% of total enrollment.

- The Segal Company completed an actuarial study of claims experience for the Non State groups, which concluded the state, and non-state groups are actuarially different. The FY 2006 non-state composite rate reflects those higher costs.

- The Benefits Website http://da.state.ks.us/ps/benefits.htm was enhanced to provide important benefits information and resources to participants and agencies.

- Approximately 16,150 participants or 46% of eligible employees utilized the Web Based Open Enrollment system to make elections for their PY 2006 Health Plan coverage.

- The trend of higher HMO enrollments and declining PPO enrollments continues.

2005 ACTIVITIES & ACCOMPLISHMENTS

Plan Year 2005 saw a continuation of the trend established in 2004 to reduce the rate of cost increases in the State of Kansas Health Benefits Program. Faced with continuing double digit increases in health and prescription drug costs, changes were made to the 2004 Plan design to encourage participants to be better consumers of health care services. Preliminary results from Plan Year 2004 indicated that participants were making better-informed decisions resulting in cost effective purchasing behavior. With those results, the decision was made to not make any additional Plan design changes for 2005. Analysis of the 2005 utilization data indicates that the positive trends established in PY 2004 continued in PY 2005. The Plan is in good financial standing with much lower cost trends than seen in the immediate past. With these results, the HCC was able to make modest Plan design enhancements for Plan Year 2006 and increase the employer contribution for dependent coverage. Following is detailed information regarding the 2005 Plan.

Requests For Proposals

The HCC released Requests for Proposal (RFP) 07858 on January 14, 2005 to obtain competitive proposals from qualified vendors for Medical coverage. The RFP sought proposals for Health Maintenance Organizations, Preferred Provider Organizations, Medicare Supplemental Plans, TriCare Supplemental Plans, High Deductible Health Plans (with Health Savings Account options) on either a fully insured or self insured basis. Subsequent to negotiations, the HCC awarded three-year contracts, effective January 1, 2006.

Health Maintenance Organization (Fully Insured)

Premier Blue (Blue Cross Blue Shield of Kansas)
Coventry Health Care of Kansas
Preferred Plus of Kansas

Preferred Provider Organization (Fully Insured)

Coventry Health Care of Kansas

Preferred Provider Organization (Self Insured with Third Party Administrator)

Blue Cross Blue Shield of Kansas

Qualified High Deductible Health Plan (Fully Insured)

Coventry Health Care of Kansas

Retiree – Direct Bill Plans

Blue Cross Blue Shield of Kansas to administer Kansas Senior Plan C (Self Insured Medicare Supplement)
Coventry Medicare Advantra Freedom (Fully Insured)

The HCC also approved a three-year contract extension with Superior Vision Services based on past performance and favorable extension terms.

Service Area Modifications

Coventry Health Care added twenty-five counties to expand HMO access in Southeast Kansas and Missouri.

Medical Benefit Changes

There were no significant plan design adjustments for Plan Year 2005. The Commission decided to continue with plan modifications made in the previous year, which addressed factors such as, higher than anticipated participant utilization and carrier renewal rates. (Exhibit D illustrates plan utilization.)

Prescription Drug Benefit Changes

The HCC continued its multi-tiered coinsurance plan design that encourages and rewards cost-effective consumer purchasing. The overall prescription drug trend of the plan remains favorable when compared to national trends. Through proactive plan management and increased consumer awareness, the generic dispensing rate increased from 46% in PY 2004 to 50.8% in PY 2005 (see Exhibit C).

Dental Benefit Changes

There were no changes to the Dental Plan design or benefit structure.

Vision Insurance Plan Changes

There were no changes to the Vision Plan design or benefit structure. Total enrollment grew to 26,281 contracts for this voluntary benefit

Labcard

The state continued its contract with Lab*One* as a specialty vendor for the Kansas Choice and Kansas Prefer PPO plans. Lab*One* provides participants with high quality outpatient lab covered by the medical plan at 100% with no copay or deductible. Each month about 5% of the eligible participants use the Labcard. For Plan Year 2005, over 60,000 services were completed with an estimated annual savings of $750,000.

Health Insurance Portability and Accountability Act (HIPAA) – Privacy/Security

The Privacy Rule provides comprehensive Federal protection for the privacy of health information. The Privacy Rule is carefully balanced to provide strong privacy protections that do not interfere with patient access to, or the quality of, health care delivery. The Privacy Rule was implemented in April of 2003, and the Health Care Commission's (HCC) staff continued activities to maintain full implementation of the Privacy Rule by updating and amending the following:

- Appointment of a Privacy Official
- Privacy flow internally and externally
- Development, publication and distribution of policies, procedures and documents to comply with HIPAA, such as training, participant notices, authorization to release information, complaint procedures and disclosure for public health, law enforcement and legal processes.
- Development and execution of agreements with business associates and trading partners

The HIPAA Security Rule requirements became effective April 20, 2005. This rule requires the HCC to ensure confidentiality (only the right people see information), integrity (information is what was supposed to be and has not been changed), and availability (the right people can see information when needed). The security requirements apply to electronic protected health information that a covered entity creates, receives, maintains, or transmits.

The HCC implemented the Security Rule by completing a risk assessment and implementing policies and procedures to:

- Protect against reasonably anticipated threats or hazards to the security or integrity of information;
- Protect against reasonably anticipated uses and disclosures not permitted by privacy rules; and
- Ensure compliance by the work force.

In developing the security plan, consideration was given to size, complexity, capabilities, technical infrastructure, cost of procedures to comply and potential security risks. Staff was trained on HIPAA security during the second quarter, 2005.

Claims Analysis System

Thomson Medstat has the Data Analysis and Benefits Modeling contract for the Health Plan. The contract includes access to the Medstat Advantage Suite product, a web-based claims analysis and decision support system. The database in Advantage Suite includes medical, drug, and dental claims for all members in the Health Plan as well as participant eligibility data. A separate benefits modeling tool is also available.

During PY 2005, the second year of the Thomson Medstat contract, the State and Medstat used the Advantage Suite database to provide claims analyses, including:

- Cost per member per month by claim line of business;

- Cost and utilization by plan and group demographics;

- Data for MedStat's Rapid Response Reports, a one page analysis of hot topics that in 2005 included topics such as Preparing for Medicare Part D, Wellness and Preventive Care Programs, and Disease Management;

- Analysis for plan design recommendations including a preventive care allowance analysis, chiropractic and physical therapy utilization analysis, number of participants reaching dental out of pocket maximum and when, average medical out of pocket cost for families, and data for Medicare Part D decisions;

- Analysis of the impact of the LabOne program on cost and utilization;

- Special studies including a high cost patient analysis, multiple ER visit analysis, drugs administered to migraine patients in the ER, top 10 ER conditions, top 100 hospitals and providers, and maintenance drug compliance for ACE inhibitors and diabetes medications.

The following analytical projects are in progress or planned for early PY 2006:

- Specific cost drivers of acute inpatient care;
- Avoidable admissions;
- Coronary Artery Disease Study including an evaluation of the Caremark CAD management program;
- Diabetes Study;
- Claims payment audit using Medstat's Auto Audit software.

Disease Management

For the past three years, HealthQuest has contracted with Caremark (formerly AdvancePCS), the State's Pharmacy Benefit Manager to administer three disease management programs. The three programs focus on Coronary Artery Disease, Depression, and Medication Safety. They concentrate on identified areas of the Health Plan to integrate pharmacy benefit, clinical services and patient support services into programs designed to help people achieve optimal health. The goal of these programs is to assist people in maintaining or enhancing their health through better self-care and effective communication with their physician. The interventions include the use of condition or disease specific educational booklets, seasonal health reminder messages, medication cards, resource lists, telephonic outreach and other educational messaging. The programs are voluntary, confidential and provided at no cost to eligible participants.

Caremark gears interventions toward health care providers and patients in order to reinforce standards of practice improve preventive care, increase communication between the patient and healthcare team and to encourage patient self-management skills. The program has interacted with nearly 8,000 State of Kansas participants. Recent data received on the Coronary Artery Disease component show that participants have experienced a 24% decrease in medical costs, and a 10% decrease in total costs. Costs for prescription drugs have increased by 9% which reflects that program participants are following and staying with prescription recommendations.

Listening Tour

Staff conducted a listening tour in April, 2005 visiting several locations across the state. Discussions were facilitated to determine the effectiveness of the existing plan benefit design, employer contribution, and participant education/communication. Staff

also wanted feedback from the human resource officers and employees regarding the potential for a Qualified High Deductible Health Plan. This process was very effective and will continue.

State Contribution for Coverage

The State contribution of 95% for employee coverage and 35% for dependent coverage was continued. It is based upon the lowest cost Health Maintenance Organization (HMO) unless the participant lives in an area with no HMO availability. Then the contribution is based on the lowest cost Preferred Provider Organization (PPO). Other options were available to participants but the participant pays the difference in the premium cost. Utilization data indicates the "buy up" contribution approach has increased participant awareness and decision making concerning health care choices and costs.

Direct Bill Subsidy

Although Direct Bill participants continue to participate in the state employees Health Plan by paying nearly the full premium for coverage, there is a subsidy, which applies to the Kansas Choice self-insured medical premium. The subsidy ranges from $0 to $115 a month. Total cost of the subsidy for fiscal year 2005 was reduced by 30% to $537,998 funded through the agency composite rates.

Direct Bill Outreach

In addition to participating in several pre-retirement seminars throughout the year, staff conducted twenty-three (23) Direct Bill open enrollment meetings between October 28 and November 21, 2005 in fifteen locations throughout the state of Kansas.

A call-in center was available to Direct Bill participants during the open enrollment period of November 1 to November 30. This was the sixth year of the center's operation, which again was staffed by state of Kansas retirees. Over 5,300 calls were received during the open enrollment period. The majority of calls were about the new Medicare Part D, prescription drug coverage.

The *Direct Bill News*, a quarterly newsletter that provides healthcare tips, plan information, Medicare Prescription Drug updates and other items of interest to participants, is published and distributed by mail and on-line. The newsletter includes a four-page insert, *Building Better Health for Seniors*, with important health information.

Non State Employer Group Participation

Non State employer group participation is illustrated in Figures 1a-b. As of December 2005, there are ninety eight (98) groups enrolled in the Non-State plan with 6,081 contracts. New enrollments are primarily local units of government.

With the inclusion of other employer groups, the HCC decided that the non state employer group's claims experience in the Health Plan would be evaluated after the groups' enrollment reached 1,250 contracts in the self-funded plans. The utilization was analyzed by the Segal Company in 2005. It concluded the state and non-state groups

were actuarially different; the FY 2006 Non State composite rate reflects the greater utilization.

Figure 1a: Non-State Groups

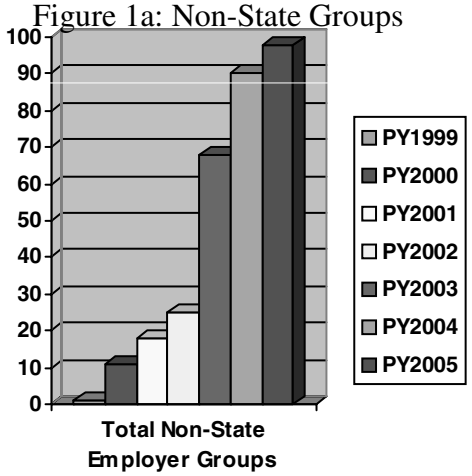
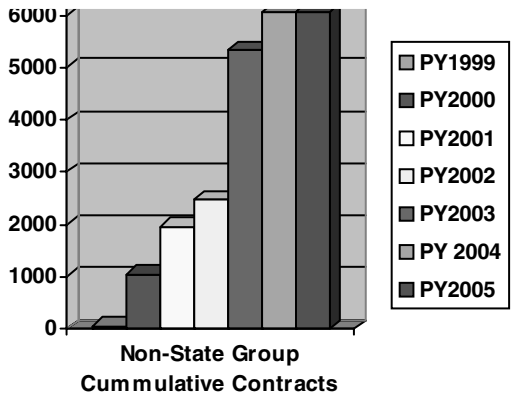


Figure 1b: Number of Contracts



NOTE: *Many of the newly added groups have enrollments of less than five so the growth in the number of entities is more prominent than the actual number of participants.*

Statewide Student Insurance Plan

The Statewide Student Insurance Plan (SWSI) administered by Student Resources and underwritten by Mega Life and Health Insurance Company is available to all full-time students at Kansas Board of Regents universities. This is the third year of the contract with Student Resources. As of the fall 2005 semester, enrollment in SWSI included 2,522 undergraduate students.

Qualified Graduate Teaching Assistant (GTA), and Graduate Research Assistant (GRA) students working at a Regents institution receive an employer contribution through SWSI toward the cost of their insurance, currently 75% of the cost for a single premium. As of the fall 2005 semester, 1,769 GRAs and GTAs were enrolled. This represents a decline of 33% despite continuing efforts through plan design modifications recommended by the SAC and the plan provider to meet the diverse needs and demographic differences at each of the institutions.

Long Term Care Insurance Plan

The contract with MedAmerica is through March 31, 2009, unless either party terminates the contract at the end of the first renewal. The Commission determined that the contract extension could help the plan in terms of building its participation and growing a reserve to make the plan more viable and attractive for participants and vendors. Despite MedAmerica's marketing efforts, enrollment remains generally flat with 705 enrollments.

PLAN YEAR 2006 PREVIEW

Employee Health Benefits

Medical Plans

- Coventry Health Care (Fully Insured HMO)
- Preferred Plus of Kansas (Fully Insured HMO)
- Premier Blue (Fully Insured HMO)
- Kansas Choice (Self Insured PPO, administered by Blue Cross Blue Shield of Kansas)
- Coventry Health Care (Fully Insured PPO)
- Coventry Qualified High Deductible Health Plan (Fully Insured with Health Savings Account administered by UMB Bank)

Medicare Part D Options

Medicare eligible participants have access to the plans listed above as well as Medicare specific options:

- Kansas Senior Plan C (Self insured Medicare Supplement administered by Blue Cross Blue Shield of Kansas). Includes dental coverage and prescription drug coverage options either with the standard Caremark plan or through an individually purchased Part D Plan or other creditable coverage.
- Coventry Advantra Freedom (Fully Insured Medicare Advantage-Prescription Drug Plan)

Medical Plan Benefit Adjustments

There will be two plan benefit improvements for Plan Year 2006. First, the rehabilitative services benefit will provide greater coverage for facility based treatment and 30 office-based visits. Second, the preventative care allowance will be increased and extended to all participants.

Rates and Employer Contribution

The State contribution of 95% for employee coverage will continue, but the dependent contribution rate will increase to an average of 45% for dependents in 2006. The contribution is based upon the lowest cost Health Maintenance Organization (HMO) unless the participant lives in an area with no HMO availability. Then the contribution is based on the lowest cost Preferred Provider Organization (PPO). Other options will be available to participants but they will have to pay the difference in the premium cost. Participants in the following Kansas HMO enrollment counties will have a choice between the low cost HMO and low cost PPO: Barber, Cloud, Mitchell, Neosho, Osborne, Reno, Rice and Wilson.

The state will also implement HealthyKIDS, a pilot program that helps eligible state employees with their premium costs for children coverage in the Health Plan.

Eligible state employees will have a 90% state contribution towards premium for children coverage and be responsible for the remaining 10%.

Service Area Modifications

New counties added to the Coventry Health Care HMO plan for 2006: Ellis, Ellsworth, Doniphan, Marshall and Russell, Kansas as well as Bates, Cedar, Hickory, Saline and St. Clair counties in Missouri.

HealthQuest

Results of the Health Risk Appraisal (HRA) in 2003/04 profiled a participant population with significant weight, cholesterol, nutrition, and fitness concerns. Therefore, the focus of HealthQuest has been on offering wellness programs that address these types of issues. Programs that are currently being offered by HealthQuest, the internal wellness program, focus on year-round wellness topics such as healthy eating, exercise, stress management and weight management. Over 4,000 employees are subscribers to these programs. In addition, LIFELINE, the Employee Assistance Program, offers health weight teleclasses that follow guidelines set forth by the National Dietetic Association, National Institute of Mental Health, and the National Diabetes Association.

Wellness Partnerships - a series of partnerships for the purpose of building and strengthening alliances with other agencies to promote wellness programs in the most efficient and effective manner have been developed. These include:

- Partnerships for Prevention program (under development with Kansas Department of Health and Environment).
- Kansas Tobacco Use Prevention Program - Quitline (produced by KDHE and promoted through HealthQuest).
- Wellness program coordination with the Kansas Department of Education wellness program.
- Participation in the Mid-America Coalition on Healthcare project on Cardiovascular Health and Disease.
- Life Coaching in relationship building, self-esteem, and job satisfaction with our AlternativesEAP vendor.
- Weight Management and Nutrition (AlternativesEAP and KU Medical Center). Also build a relationship with county extension services to communicate with employees in rural areas and especially employees of eligible non-state entities.
- Bi-monthly online wellness newsletter (Scott Publishing).
- Continuation of Disease Management programs in coronary artery disease, depression, and medication safety with Caremark.

- Re institute a network of agency wellness coordinators to build the capacity of HealthQuest programming.

- Coordination with the State Thanks and Recognition (STAR) program to identify vendors who provide health and wellness related goods and services not covered in the state health plan at reduced costs to state employees. Some examples include health club memberships, fitness equipment and hearing specialists.

Statewide Student Insurance Plan

The Statewide Student Insurance Plan (SWSI) will continue to be available to all full-time students, qualified Graduate Teaching Assistant (GTA), and Graduate Research Assistant (GRA) students working at a Regents institution.

PARTICIPATION

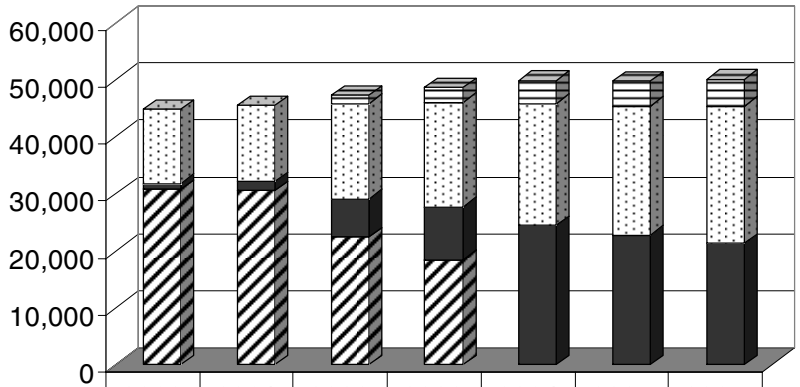
Active employees, retirees, employees receiving long term disability payments, employees on leave without pay, non-state employer groups, qualified beneficiaries on COBRA, as well as other individuals identified in K.A.R. 108-1-1, K.A.R. 108-1-3, and K.A.R. 108-1-4 participate in group health insurance plans. During PY 2005 there was an average of 49,781 contracts covering approximately 87,834 lives. The contracts included:

- 34,799 Active State of Kansas employees,
- 5,659 Active Non State employees (Education and local units),
- 9,140 Direct Bill participants, and
- 183 COBRA participants

See figure 2 for an illustration of participation by plan type.

Participation census data for Plan Year 2005 is shown at Exhibit E.

Figure 2: Plan Participation (Contracts) by Category 2000 - 2006 (projected)



	2000	2001	2002	2003	2004	2005	2006
Medicare Supplemental			1,442	2,599	4,120	4,342	4,692
HMO	13,038	13,362	16,751	18,419	21,344	22,634	24,110
PPO	1,005	1,526	6,660	9,218	24,467	22,805	21,329
Managed Indemnity POS	30,823	30,590	22,430	18,463			
Total All Plans	44,866	45,478	47,283	48,699	49,931	49,781	50,131

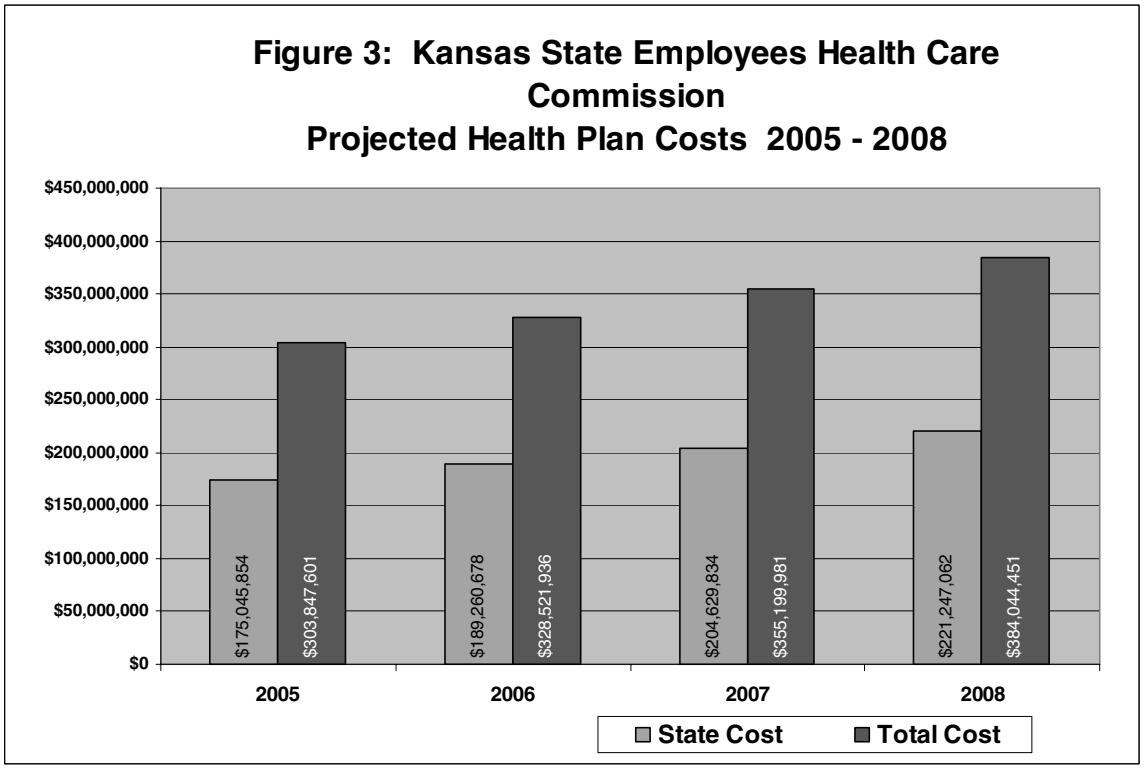
COST PROJECTIONS

Figure 3 illustrates the unaudited annualized costs for 2005 as well as the anticipated cost projections for the next three calendar years.

An unknown factor at this time is the on-going rate of medical inflation. However, the following cost increase assumptions were used to project health plan costs for Plan Years 2006 through 2008:

- Self-insured PPO claims: 10.2%
- Self-insured Medicare retiree claims: 7.5%
- Insured HMO/PPO premiums: 6.2%
- Self-insured Rx claims: 9.1%
- Self-insured dental claims: 7.0%

These trend assumptions may change as additional data becomes available.



Please note the following in relation to Figure 3:

- For the purposes of this estimate, impact of any new contribution structure on future employee costs has not been projected.
- Any future increase in total lives has not been considered.
- Vendor cost increase estimates for 2006 and beyond have been relied upon.

Overall Plan Cost

Per Figure 3 above, the total annualized cost of the Kansas group health plan for Plan Year 2005 was approximately $303,848,000. This is 1.97% lower than estimated

cost shown in the Plan Year 2004 Annual Report. The annual total cost estimate is revised each year as more recent claims experience is collected. Of the $303.8 million cost of the Health Plan, $175.0 million represents current estimated expenditure of the state and other employer groups.

A material reduction in actual costs from cost projections is consistent with experience nationally for large employers during calendar year 2005, as national trends for both medical and prescription drug coverage continued to drop. The Kansas group health plan experienced actual trends well below trends used to project expected costs for 2005.

Reserve Accounts

Current reserves held by the Health Plan are analyzed periodically to ensure they are adequate to cover the Incurred But Not Reported (IBNR) claim liability that arises from the self-funded coverage options. As of December 31, 2005, the reserves held by the State of Kansas for the estimated IBNR liability are adequate.

COST CONTAINMENT ALTERNATIVES AND STRATEGIES

The HCC continues to study and develop cost containment alternatives. The HCC believes that both the improvement in the overall health of plan participants as well as the control of unnecessary utilization to be cost containment initiatives. These concepts are incorporated into Requests for Proposal and medical, dental and pharmacy benefit management contracts. The plan changes previously implemented in 2004 are building consumer awareness, encouraging preventative treatments, and limiting premium increases which is reflected in the decrease of the rate of increase of the cost of the health plan The following information details cost containment alternatives and strategies the HCC is either researching or considering.

Strategic Areas

Medical. The PPO plan design provides first dollar coverage without a deductible. It emphasizes the use of coinsurance, which alerts participants to the total cost of services. It provides coverage for preventive services. It allows participants to choose providers including those that do not contract with the selected medical plan's network. In these cases, providers are free to bill whatever they choose. The state's self-funded medical plans utilize a cost management service to negotiate claims payment with non network providers to achieve savings for the plan and its participants. The voluntary Lab Card service with the self-insured PPO provides value-added benefits or services with no out of pocket costs to participants and reductions in service costs to the plan.

In the HMO plans, copayments can be adjusted to limit premium increases and to reflect the plans' actual trends. In addition, the concept of coinsurance for major diagnostic tests and in patient service in the HMO plan design also provides participants with information about the total cost of services.

The state will continue to encourage competition and development of managed care networks in non-metropolitan areas of the state to increase participation in cost effective options. Both Premier Blue (HMO) and the Coventry HMO expanded networks in non metropolitan areas for PY 2006. Additionally, the HCC is making Coventry Advantra Freedom available to Medicare eligible Direct Bill participants in 2006.

Prescription drug. Nearly one-fifth of the health care dollars goes toward prescription drugs. At the national level, drug costs are expected to continue to rise at a double-digit inflation rate for the next three or four years. The current progressive five-tiered plan design encourages and provides an incentive to use generic and preferred brand drugs to maximize plan and participant savings. Increased use of the mail order pharmacy is expected due to its ease and because of greater savings. Emphasis will continue on enforcing contractual performance guarantees. Other methods and policies will be considered as new, more expensive drug therapies are introduced.

Dental Plan. Plan design considerations will continue to focus on encouraging and supporting preventive care activities of plan participants.

Buy Up. Initially implemented with the five-tier co-insurance structure with the prescription drug plan in Plan Year 2000, the concept was used again in Plan Year 2004 when employer funding changes were made to provide participants an incentive to select more cost effect medical plans in areas were choices were available. An analysis of the trends of both of these buy up initiatives prior to the change and after the change show a marked increase in participants selecting more cost effective drugs and medical plans and a marked decrease in cost trends. In terms of the prescription drug trend, it continues to be significantly below the national average. In terms of the medical plan, nearly 6,000 contracts have moved to HMOs from the PPOs and former Managed Indemnity POS plans. Projected rate increases for 2006 through 2008 is 6.2% for HMOs and insured PPO option vs. 10.2% increases for the self insured PPO resulting in a net savings of 4%. Continued application of the buy up concept will be researched and implemented as appropriate.

Stop Loss. Claims and utilization data will continue to be monitored very closely to determine any future need for stop loss insurance. Should the claims analysis system indicate unpredictable viability in the group experience, stop loss coverage may be considered to protect the stability of the plan.

Disease management programs. A comparison of the percent of participants vs. the percent of dollars paid over the past several years (Exhibit D) indicates that the percent of participants moving from the category of either not receiving services or accessing only routine services to the category of more chronic health conditions continues to increase. Continued consumer education and emphasis on management of vendor and carrier relationships within the Health Plan are keys to lowering healthcare costs for the long term. More emphasis is being directed at disease management programs, which build awareness and give participants tools, such as information on treatment options and physician and hospital care to better manage their own care. Pursuing and obtaining return on investment (ROI) performance guarantees with vendors is a viable goal that could lead to higher level of performance that control healthcare costs.

Wellness. Prevention and wellness initiatives continue to be a top priority for the health plan. The increase of benefits for these services in 2006 will be monitored to determine effectiveness. Additionally, the HCC will continue to search out vendors that place a high emphasis on prevention and wellness at the individual participant level. Premier Blue and the Coventry HMO are excellent examples of proactive information and specific action plans available to plan participants.

Consumer Driven Plans. With the implementation of the High Deductible Health Plan (HDHP) in 2006, analysis can be performed on utilization and trends of this option compared with the other medical options to determine whether the concept can be utilized in other segments of the Plan. Although the limited first year enrollment in the HDHP is not expected to affect the remaining population, it will be monitored to determine if “anti-selection” may become and issue.

Quality. With the ability to determine and define quality indicators, performance benchmarks can be established and plan design modifications made that will reward provider and participant adherence to the standards.

Performance standards: All carriers contracting with the state of Kansas for the provision of health benefits have agreed to performance standards in the areas of:

- Membership Processing and Identification Cards
- Timeliness of Pre-authorization/Predetermination(s)
- Enforcement of provider contracts
- Telephone responsiveness
- Claims processing accuracy and timeliness

It is the expectation of the HCC that these performance standards will increase participant satisfaction and improve administrative effectiveness over the next several years. Performance guarantees will continue to be refined to address current and emerging contracting issues. Staff will review "best practices" of other employer plans to assure that the state is current in this important plan management area.

Consumer awareness is emphasized so that participants can make wise choices in the medical plan utilization, thus playing an active role in controlling costs. The enrollment materials, both printed and internet based have been revised to provide participants with better plan design information and decision making tools. The HCC continues to look to the EAC and SAC, as well as other focused participant groups for ideas and support for changes in the Health Plan.

FUTURE DIRECTION

On May 10, 2005, the Governor signed into law, House Substitute for Senate Bill No. 272. With this bill, the Kansas Health Policy Authority was established as a state agency within the executive branch of government, effective July1, 2005. The bill states, in part: *"The Kansas health policy authority shall develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Kansas health policy authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs."*

The bill established the Division of Health Policy and Finance (DHPF) within the Department of Administration, effective July 1, 2005. The Director of DHPF is responsible for health care planning, administration and purchasing and analysis of health data with respect to several health programs administered by the state of Kansas through Fiscal Year 2006. During Fiscal Year 2006, several health components formerly within the Kansas Department of Social and Rehabilitation Services and Kansas Department of Health and Environment will be moved to the DHPF.

Ultimately, on July 1, 2006, the DHPF will be abolished and the Director of Health Policy and Finance, Kansas Health Policy Authority shall coordinate and administer programs previously under the supervision of the DHPF. On July 1, 2006, the Kansas Health Policy Authority shall assume operational and purchasing responsibility for the state health care benefits program as provided in K.S.A. 75-6501 through 75-6523, and amendments.

From a practical standpoint, administration of the state health care benefits program staff and activities were moved from the Division of Personnel Services to the DHPF on July 1, 2005.

Exhibit A to 2005 HCC Annual Report

Employee Advisory Committee

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Exhibit B to 2005 HCC Annual Report

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Exhibit C to 2005 Annual Report
Generic Dispensing Rate

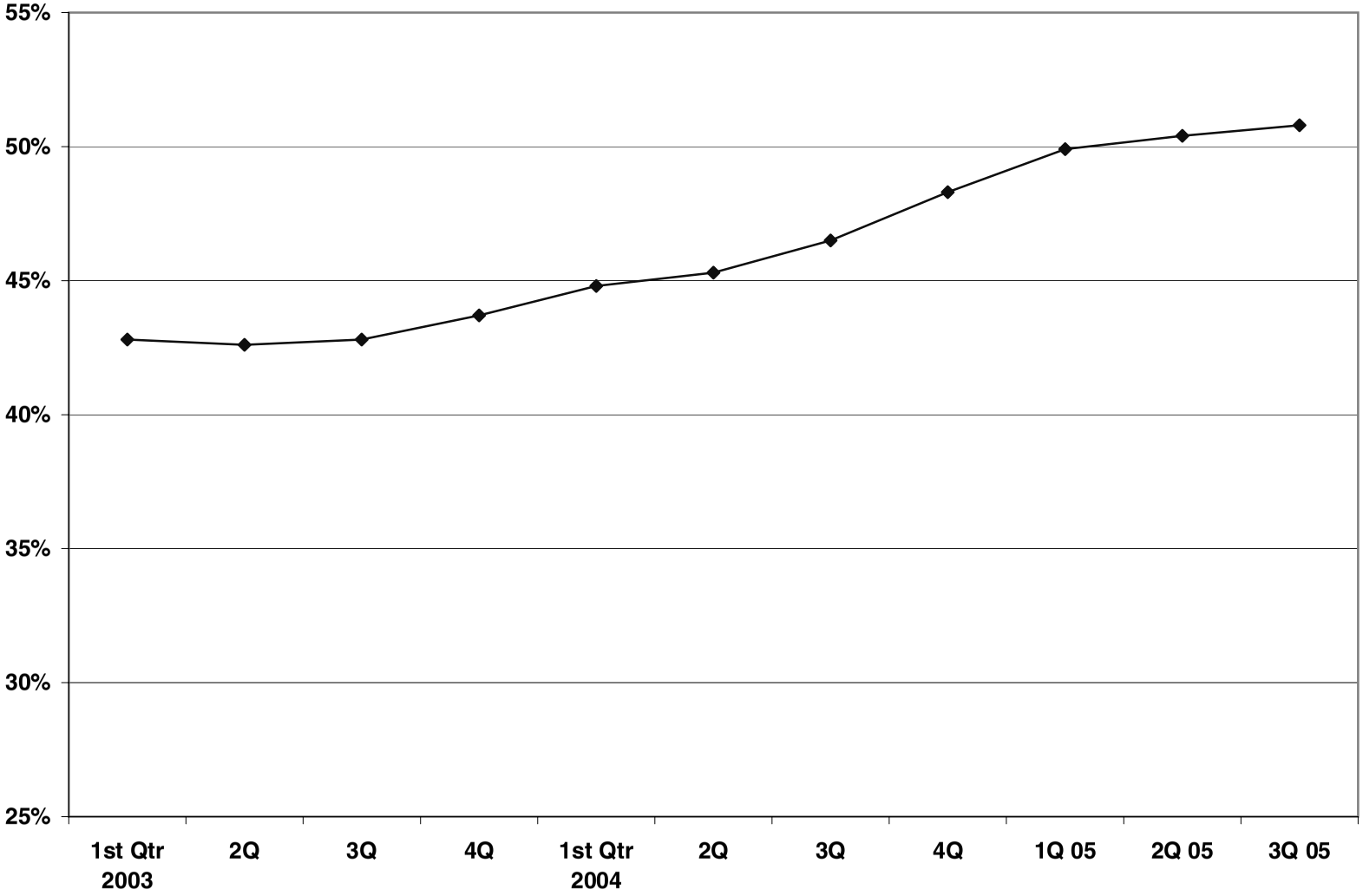
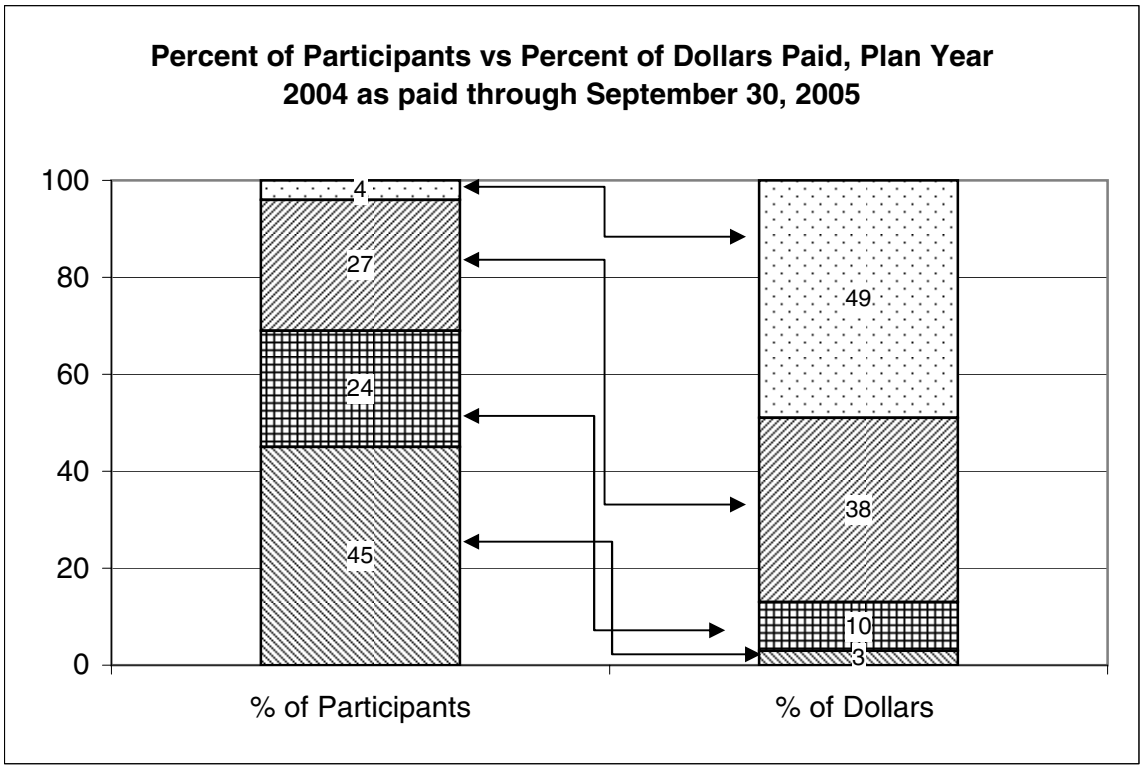


Exhibit D to 2005 Annual Report



This chart was created in the fall of 2005 and shows the utilization of members for plan year 2004. In 2004 the Plan covered an average of 89,644 lives. See footnotes below for more detail.

As indicated by the chart, 4% of participants use nearly half (49%) of all claims dollars. This distribution is typical of large groups and reflects participants who have catastrophic, life threatening illnesses and injuries.

On the other hand, 45% of the participants use only 3% of the claims dollars. This is the group that either does not seek health care or goes only for routine check-ups.

The remaining 51% of participants use 48% of the claims dollars. These participants are most likely to have chronic health conditions that could, perhaps, be managed more cost effectively with lifestyle changes or by following physician's orders more closely. This is the group where disease management services are most effective and on which awareness and intervention efforts are focused.

*Participants include active employees, retired employees, COBRA participants, and any other direct bill participants for the State of Kansas and participating non-state employers.

**Dollars Paid does not include capitated claims from HMO plans, administrative costs for Kansas Choice, Kansas Senior Plan C, Kansas Prefer or Caremark, or premiums paid by the State or dollars paid by the participant.

Exhibit E to 2005 Annual Report

STATE OF KANSAS

2005 GROUP HEALTH INSURANCE ENROLLMENT
BY TYPE OF PARTICIPANT

Grand Total Covered Lives (State & Non-State Active, Direct Bill, & COBRA)					
Type of Participant	Jan-05	Apr-05	Jul-05	Oct-05	Average
Active State Employees	35,140	35,090	34,483	34,483	34,799
Active State EE Dependents	30,564	30,375	29,813	29,554	30,077
Total Covered Lives	**65,704**	**65,465**	**64,296**	**64,037**	**64,876**
Direct Bill State Retirees	8,821	8,798	8,794	8,781	8,799
Direct Bill State Ret Dependents	2,798	2,770	2,788	2,767	2,781
Total Covered Lives	**11,619**	**11,568**	**11,582**	**11,548**	**11,579**
COBRA State Participants	161	147	155	181	161
COBRA State Dependents	65	63	49	83	65
Total Covered Lives	**226**	**210**	**204**	**264**	**226**
Active Educational Employees	3,518	3,516	3,487	3,419	3,485
Active Educational EE Dependents	2,620	2,621	2,583	2,534	2,590
Total Covered Lives	**6,138**	**6,137**	**6,070**	**5,953**	**6,075**
Direct Bill Educational Retirees	295	288	289	311	296
Direct Bill Educational Ret Dependents	91	88	85	93	89
Total Covered Lives	**386**	**376**	**374**	**404**	**385**
COBRA Educational Participants	17	14	12	12	14
COBRA Educational Dependents	5	5	4	5	5
Total Covered Lives	**22**	**19**	**16**	**17**	**19**
Active Local Units of Government Employees	2,193	2,172	2,172	2,156	2,173
Active Local Units of Govt EE Dependents	2,459	2,418	2,416	2,414	2,427
Total Covered Lives	**4,652**	**4,590**	**4,588**	**4,570**	**4,600**
Direct Bill Local Units of Govt Retirees	41	30	55	55	45
Direct Bill Local Units of Govt Ret Deps	15	22	21	22	20
Total Covered Lives	**56**	**52**	**76**	**77**	**65**
COBRA Local Units of Govt Participants	6	9	8	8	8
COBRA Local Units of Govt Dependents	3	4	0	1	2
Total Covered Lives	**9**	**13**	**8**	**9**	**10**
Grand Total Covered Lives	**88,812**	**88,430**	**87,214**	**86,879**	**87,834**

Reflects dependents on medical coverage

Exhibit F - 2005 State of Kansas Annual Report

Kansas State Employees Health Care Commission
2005 Comparison of Actual to Estimated
Health Plan Costs (Unaudited)

	Actual 2005 Year-To-Date	Annualized[1]
1. **2005 Estimated Total Cost**		$309,848,096
2. **2005 Actual Total Cost**		
a. Kansas Choice Self-Insured Claims	$55,377,265	$73,836,353
b. Kansas Senior Plan C Self-Insured Claims	$5,976,556	$7,968,742
c. Kansas Prefer Self-Insured Claims	$4,439,980	$5,919,973
d. Caremark Rx Drug Claims	$46,494,210	$61,992,280
e. Delta Dental Claims	$9,406,048	$18,812,096
f. Superior Vision Premiums	$2,180,066	$2,906,755
g. Insured HMO/PPO Premiums	$94,485,745	$125,980,993
h. ASO Fees	$4,822,807	$6,430,409
Total	$223,182,677	$303,847,601
3. **2005 Employee, COBRA, Direct Bill Contributions**		$128,801,747
4. **2005 State Cost**		
a. Estimated		$171,675,197
b. Actual [2. - 3.]		$175,045,854
c. % Difference [4b./4a. -1]		1.96%

Two components account for virtually the entire variance between the estimated and actual 2005 State Cost. First, the trend factors used by SEGAL in projecting future costs are inherently cautious. Although the State of Kansas' annual medical and prescription drug trends are below national averages, it is SEGAL's position that frequent significant changes to trend factors (changes of 50 to 100 basis points or more) is imprudent. Second, utilization of health care benefits were substantially lower. For example, the number of in-patient admissions and days-per-admissions (both of which are among the highest costing benefits) - decreased dramatically for virtually all Plans.

1. These values were developed by annualizing available claims data. Intra-year trend, deductible leveraging, and migration were not considered. Data has not been audited further.